ELSEVIER

Patient Education and Counseling 63 (2006) 188–195

Patient Education and Counseling

www.elsevier.com/locate/pateducou

Development and communication of written ethics policies on euthanasia in Catholic hospitals and nursing homes in Belgium (Flanders)

Chris Gastmans [a,*], Joke Lemiengre [a], Bernadette Dierckx de Casterlé [b]

[a] *Centre for Biomedical Ethics and Law, Faculty of Medicine, Catholic University of Leuven, Belgium*
[b] *Centre for Health Services and Nursing Research, Faculty of Medicine, Catholic University of Leuven, Belgium*

Received 28 June 2005; received in revised form 4 October 2005; accepted 19 October 2005

Abstract

Objective: To describe whether and how Catholic hospitals and nursing homes in Belgium (Flanders) have developed written ethics policies on euthanasia and communicated these policies to their employees, patients, and patient's relatives.
Methods: A cross-sectional mail survey of general directors of Catholic hospitals and nursing homes in Belgium (Flanders).
Results: Of the 298 targeted institutions, 81% of hospitals and 62% of nursing homes returned complete questionnaires. A high percentage of Catholic hospitals (79%) and a moderate percentage of nursing homes (30%) had written ethics policies on euthanasia. Both caregivers and healthcare administrators were involved in the development and approval of these policies. Physicians and nurses were best informed about the policies. More than half of the nursing homes (57%) took the initiative to inform both residents and relatives about the policies, while only one hospital did so.
Conclusion: The high prevalence of written ethics policies on euthanasia in Flemish Catholic hospitals may reflect the concern of healthcare administrators to maintain the quality of care for patients requesting euthanasia. However, the true contribution of these policies to quality end-of-life care and to supporting caregivers remains unknown and needs further research.
Practice implications: Legislation and centrally developed guidelines might influence healthcare institutions to develop ethics policies.

Keywords: Euthanasia; Institutional policies; Ethics; Communication; Postal survey

1. Introduction

Worldwide, caregivers in hospitals and nursing homes are confronted with patients requesting euthanasia, regardless of the existence of laws governing it. Of all deaths, euthanasia accounts for 1.70–2.59% in The Netherlands, 1.70% in Australia, 0.30–1.20% in Belgium (Flanders), 0.27% in Switzerland, 0.06% in Denmark, and 0.04% in Italy [1–4]. The lack of clarity and communication in healthcare practice about how to care for patients requesting euthanasia is worrisome [1,5]. There is a growing awareness that healthcare institutions bear significant responsibility in maintaining the quality of care for their patients at the end of life – including those who request euthanasia – and in supporting their caregivers [6,7]. To take on this challenge, a first step for institutions would be to develop a written ethics policy on euthanasia and to adequately communicate this policy to caregivers, patients, and relatives [8–10].

In 2002, Belgium became the second country after The Netherlands to enact a law on euthanasia [11]. This law allows euthanasia only under strict conditions and to be performed only by physicians [11]. During the period preceding the enactment of this law, the Belgian Senate organized public hearings to address various issues regarding euthanasia. Flemish Catholic healthcare institutions played a significant role in these hearings by directing attention to the importance of good palliative care for

* Corresponding author at: Centre for Biomedical Ethics and Law, Faculty of Medicine, Catholic University of Leuven, Kapucijnenvoer 35, B-3000 Leuven, Belgium. Tel.: +32 16 33 69 53; fax: +32 16 33 69 52.
E-mail address: Chris.Gastmans@med.kuleuven.be (C. Gastmans).

0738-3991/$ – see front matter
doi:10.1016/j.pec.2005.10.004

patients requesting euthanasia [8,12]. Caritas Flanders, the umbrella organization that promotes collaboration among Catholic healthcare institutions in Flanders, drafted a position paper, ''Caring for a dignified end of life,'' [8] together with a clinical practice guideline, ''Facing requests for euthanasia'' [13]. On 17 May 2002, the day after the Belgian parliament passed the Act on Euthanasia, the position paper and the clinical practice guideline were sent to all Catholic healthcare institutions in Flanders, together with the call to develop proper institutional ethics policies on euthanasia. By disseminating these two documents [8,13], Caritas Flanders has attempted to improve the clarity of euthanasia ethics policies and the communication of these policies to caregivers, patients, and their relatives.

To date, concrete data remain unavailable concerning written ethics policies on euthanasia in Flemish Catholic healthcare institutions. The lack of relevant data prompted us to undertake the present study. The first part of our study investigated the content of written ethics policies on euthanasia in Catholic healthcare institutions [14]. Here, we describe the results of the second part of our study, which examined whether and how Flemish Catholic hospitals and nursing homes have developed written ethics policies on euthanasia and whether they have communicated these policies to others. Specific objectives of the study were to describe the following:

- The prevalence of written ethics policies on euthanasia in these institutions;
- The reasons why ethics policies on euthanasia were or were not developed by these institutions;
- The parties involved in the development and approval of ethics policies on euthanasia in these institutions;
- Whether the ethics policies were made known to stakeholders of these institutions.

2. Catholic healthcare institutions and euthanasia in Belgium (Flanders)

The study was carried out in Flanders, the Dutch-speaking part of Belgium, where 60% (5.9 million inhabitants) of the population lives. The majority (81%) of the Flemish population is Roman Catholic. Catholic hospitals and nursing homes represent 56% (47/84) and 33% (251/761), respectively, of the total number of hospitals and nursing homes in Flanders.

Like other organizations, in recent years Catholic healthcare institutions have undergone the influence of social trends such as the rise in philosophical-religious pluralism, also among Christians [15,16]. The creative dialogue between 'Catholic identity' en 'pluralist context' has led to the fact that Caritas Flanders encouraged Catholic healthcare institutions not merely to reject the euthanasia act, but to limit the application of the Act in two ways [8,13]. Firstly, according to Caritas Flanders, the application of euthanasia should be limited to very exceptional cases ('states of necessity') of competent terminally ill patients, and thus not in case of non-competent patients and non-terminally ill patients. Secondly, Catholic healthcare institutions are encouraged by Caritas Flanders to add another condition to the application of euthanasia, namely the palliative care filter. The aim of the palliative filter procedure is to ensure all palliative possibilities have been investigated, and that all involved have thoroughly consulted each other on the euthanasia request as well as the remaining palliative possibilities [12]. The Belgian Euthanasia Act, however, does not contain the palliative filter procedure as a due care criterion.

The first part of our study on the content of ethics policies [14] revealed that most of the ethics policies in Catholic healthcare institutions reflect the clear conditions Caritas Flanders described in their position paper and clinical practice guideline [8,13]. Flemish Catholic hospitals and nursing homes (83% and 85%, respectively) considered euthanasia an option only in exceptional cases, when both legal due care criteria and the palliative filter procedure had been fulfilled in cases of competent terminally ill patients. Euthanasia requests, via advance directives, from incompetent terminally ill patients, and even more from non-terminally ill patients encounter much more resistance from Catholic healthcare institutions.

The willingness – at least somehow – to deal with euthanasia requests within the institution perhaps reflect developments in the field of Catholic healthcare institutions in Flanders. The statements of the Roman Catholic Magisterium on euthanasia are, in Catholic healthcare institutions, no longer generally accepted as the legitimate foundation for developing their own ethics policies [17]. On the other hand, almost all Catholic healthcare institutions regard the mere application of the due care criteria provided for in the euthanasia law as insufficient to justify euthanasia. By introducing the additional condition of a palliative filter procedure, they aim at a very restrictive application of the law. Anyway, given this repeated encouragement of Caritas Flanders for an open and transparent communication, it becomes clear that church pronouncements are no longer a force, which limit discussion on euthanasia in Catholic healthcare institutions.

3. Methods

3.1. Design

A cross-sectional, descriptive survey was used. The study was conducted as part of a larger survey examining the ethics policies on end-of-life decisions in Catholic hospitals and nursing homes in Belgium (Flanders).

3.2. Sample

All Flemish Catholic hospitals and nursing homes received the postal questionnaire by mail. We obtained

the addresses of these institutions from 1 January 2003 member list of Caritas Flanders, an organization that assembles all Catholic healthcare institutions in Flanders. We mailed the questionnaire to the general directors of these institutions, because we assumed that they would have a clear general view on the written ethics policy on euthanasia in their institution.

3.3. Data collection

The data were collected between 1 October 2003, and 15 February 2004. The questionnaire provided an anonymity option for the responder, ensuring that the information returned to us could in no way lead to the identification of individual healthcare institutions. The general directors were given assurances that the information they provided would be used for no other purpose than answering the research questions and that the research would in no way lead to legal consequences for the participants.

3.4. Questionnaire—validity and reliability

The questionnaire was based on a Dutch, semi-structured questionnaire [6,9]. Although, The Netherlands and Flanders share the same language as well as a similar culture and history, we adapted some parts of the questionnaire to accommodate legal, ethical, and organizational differences on healthcare and euthanasia. To guarantee the content validity of the revised questionnaire, our alterations were guided by a detailed review of the literature [1,3,7,18–21]. Definitions of terms (e.g., 'ethics policy' and 'euthanasia') were clearly explained in the questionnaire. The face validity was assessed by presenting the adapted questionnaire to the general directors of three healthcare institutions and to six Belgian experts in the area of medical end-of-life decisions. The purpose of this pilot test was to ensure that the questionnaire yielded all the data that were required for our larger study.

The revised questionnaire contained a total of 52 questions grouped into one general and five specific sections. The general section consisted of questions about the type of healthcare institution and the presence of channels for ethical discussion. The five specific sections consisted of questions about the prevalence, content, development, and communication of the institutional ethics policy on (1) euthanasia, (2) assisted suicide, (3) withdrawing or withholding life-sustaining treatment, (4) symptom and pain relief, and (5) palliative sedation. The

Table 1
Development of written ethics policies on euthanasia in Catholic hospitals and nursing homes in Belgium (Flanders)

	Hospitals No. (%) ($n = 30$)	Nursing homes No. (%) ($n = 47$)
Euthanasia policy was formulated in		
2002	10 (33)	8 (17)
2003	20 (67)	39 (83)
Reasons for development of an ethics policy[a]		
Approval of Act on Euthanasia on 28 May 2002	24 (80)	39 (83)
Distribution of Caritas Flanders documents	15 (50)	29 (62)
Need for a general guideline on euthanasia	11 (37)	27 (57)
Approval Act on Palliative Care on 14 June 2002	4 (13)	27 (57)
Confrontation with euthanasia requests	4 (13)	23 (49)
Other	2 (7)	5 (11)
	Hospitals No. (%) ($n = 6$)[b]	Nursing homes No. (%) ($n = 100$)[b]
Reasons for not developing an ethics policy[a]		
Euthanasia is the decision of physicians	5 (83)	32 (32)
Not confronted with euthanasia requests	3 (50)	67 (67)
Every case is different	0 (0)	14 (14)
Everybody is supposed to know euthanasia is not permitted	0 (0)	13 (13)
Approval of Act on Euthanasia on 28 May 2002	2 (33)	9 (9)
Oral agreements	0 (0)	10 (10)
Other	0 (0)	10 (10)
	Hospitals No. (%) ($n = 8$)	Nursing homes No. (%) ($n = 109$)
Future plans of healthcare institutions that had no euthanasia policy at time of survey		
In the process of developing an ethics policy	4 (50)	21 (19)
Have concrete plans to develop an ethics policy in the future	2 (25)	34 (31)
Have no plans to develop an ethics policy	2 (25)	54 (50)

[a] Multiple responses possible.
[b] Two hospitals and nine nursing homes did not respond.

present article focuses on the questions relating to the development and communication of ethics policies on euthanasia. More detailed information on the content of the ethics policies on euthanasia have been described elsewhere [14].

3.5. Definitions

According to Article 2 of the Belgian Act on Euthanasia, *euthanasia* is defined as intentionally terminating life by someone other than the person concerned, at the latter's request [11]. 'Someone other' is understood to be a doctor, and 'terminating life' is interpreted as the administration of a lethal dose of medication. This definition is also used in the Dutch Act on Euthanasia [22] and in the literature [3,6,10,18]. In the present study, *written institutional ethics policy* is defined as the written agreements (procedures, guidelines, protocols, etc.) authorized by the management of a healthcare institution to guide caregivers when approaching a problem that includes a decision-making process and/or phased plan [6].

3.6. Ethical considerations

The ethics committee of Caritas Flanders approved the study and gave its written consent to carry out the research. Participation of the institutions was completely voluntary. The researcher (CG) guaranteed the strictly confidential treatment of the data. Returning the completed questionnaire counted as informed consent to participate in the study.

3.7. Analyses

The data were analysed in terms of percent frequency for the participating hospitals and nursing homes.

4. Results

4.1. Response

Of the 298 institutions surveyed, 65% (194) returned a completed questionnaire. The response rate from hospitals and nursing homes was 81% (38/47) and 62% (156/251), respectively. A number of institutions opted to reveal their identity when returning the questionnaire. This made it possible to determine the geographical location of 76% (29) of the participating hospitals and 66% (103) of the participating nursing homes. These institutions were distributed throughout all five provinces of Flanders.

4.2. Prevalence and development of written ethics policies on euthanasia

Seventy-nine percent of the Catholic hospitals (30/38) and 30% of the nursing homes (47/156) had a written ethics policy on euthanasia at the time the questionnaire was completed (Table 1). In 67% of these hospitals and in 83% of these nursing homes, the ethics policies were formulated in 2003; the policies for the remaining institutions were formulated in 2002.

In the majority of these hospitals (80%) and nursing homes (83%), the approval of the Act on Euthanasia (2002) was the most frequently mentioned reason for the development of a written ethics policy on euthanasia. Other frequently mentioned reasons include receiving the Caritas Flanders documents (position paper and clinical practice guideline) and experiencing the need for euthanasia guidelines in daily clinical practice.

Twenty-one percent (8) of the hospitals and 70% (109) of the nursing homes did not have a written ethics policy on euthanasia at the time of the survey. Especially for the hospitals, the most frequently mentioned reason for not developing an ethics policy was that, in their opinion, euthanasia is the responsibility and decision of physicians (83%). The other frequently mentioned reason was that the hospitals (50%) and nursing homes (67%) were not confronted with euthanasia requests.

In healthcare institutions without a written ethics policy, the general directors of 75% of the hospitals and 50% of the nursing homes reported that they were either in the process of drafting a policy or had plans to do so in the future.

4.3. Partners involved in the development and approval of written ethics policies on euthanasia

The ethics committees of all hospitals were involved in the development of written ethics policies (Table 2). In the

Table 2
Professionals involved in the development and approval of written ethics policies on euthanasia in Catholic hospitals and nursing homes in Belgium (Flanders)

	Hospitals No. (%) ($n = 30$)	Nursing homes No. (%) ($n = 47$)
Partners involved in developing ethics policy[a]		
Ethics committee	30 (100)	24 (51)
Board of directors	5 (17)	29 (62)
Daily managerial staff	7 (23)	22 (47)
Palliative support team	9 (30)	12 (26)
Medical board	3 (10)	1 (2)
Other	1 (3)	5 (11)
	Hospitals No. (%) ($n = 30$)	**Nursing homes No. (%) ($n = 46$)[b]**
Partners involved in approving ethics policy[a]		
Ethics committee	26 (87)	21 (46)
Board of directors	20 (67)	40 (87)
Daily managerial staff	16 (53)	31 (67)
Palliative support team	13 (43)	8 (17)
Medical board	12 (40)	2 (4)
Other	3 (10)	5 (11)

[a] Multiple responses possible.
[b] One nursing home did not respond.

Table 3
Communication of written ethics policies on euthanasia in Catholic hospitals and nursing homes in Belgium (Flanders)

	Hospitals No. (%) ($n = 30$)	Nursing homes No. (%) ($n = 45$)[a]
Institutional physicians		
Yes, without request	24 (80)	30 (67)
Yes, upon request	2 (7)	8 (18)
No	4 (13)	7 (16)
	Hospitals No. (%) ($n = 30$)	Nursing homes No. (%) ($n = 45$)[a]
Institutional nurses		
Yes, without request	22 (73)	38 (84)
Yes, upon request	5 (17)	3 (7)
No	3 (10)	4 (9)
	Hospitals No. (%) ($n = 30$)	Nursing homes No. (%) ($n = 45$)[a]
Other institutional caregivers		
Yes, without request	17 (57)	35 (78)
Yes, upon request	6 (20)	5 (11)
No	7 (23)	5 (11)
	Hospitals No. (%) ($n = 30$)	Nursing homes No. (%) ($n = 45$)[a]
General practitioners		
Yes, without request	10 (33)	30 (67)
Yes, upon request	8 (27)	8 (18)
No	12 (40)	7 (16)
	Hospitals No. (%) ($n = 30$)	Nursing homes No. (%) ($n = 44$)[b]
Patients/residents		
Yes, without request	1 (3)	25 (57)
Yes, upon request	10 (33)	6 (14)
No	19 (63)	13 (30)
	Hospitals No. (%) ($n = 30$)	Nursing homes No. (%) ($n = 44$)[b]
Relatives		
Yes, without request	1 (3)	25 (57)
Yes, upon request	9 (30)	6 (14)
No	20 (67)	13 (30)

[a] Two nursing homes did not respond.
[b] Three nursing homes did not respond.

majority of hospitals, the ethics committees cooperated with other concerned partners such as the palliative support team (30%) and the daily managerial staff (23%). In the nursing homes, the board of directors was the most involved partner (62%), followed by the ethics committee (51%), and the daily managerial staff (47%). In the hospitals, the ethics committees (87%) were most involved in approving ethics policies, followed by the board of directors (67%), and the daily managerial staff (53%). In the nursing homes, the board of directors (87%) was the most involved, followed by the daily managerial staff (67%), and the ethics committee (46%).

4.4. Communication of written ethics policies on euthanasia to stakeholders

The majority of general directors of both hospitals and nursing homes reported that they took the initiative to communicate the ethics policy without request to institutional physicians (80% and 67%, respectively), nurses (73% and 84%, respectively), and other institutional caregivers (57% and 78%, respectively) (Table 3). Sixty-seven percent of the nursing homes took the initiative to inform general practitioners about the policy, whereas only 33% of the hospitals did so. There were also differences with regard to the communication of the ethics policy to patients or residents and relatives. More than half of the nursing homes (57%) took the initiative to communicate their ethics policies to both residents and the residents' relatives, while only one hospital took the initiative to communicate their ethics policy to patients and their relatives.

5. Discussion and conclusion

5.1. Discussion

In interpreting the data of this study, it is necessary to consider some methodological issues. First, the overall response rate in our survey was 65%, which is satisfactory for survey research [23]. Response rate from hospitals (81%) was high. Because all Catholic hospitals in Flanders were invited to participate in the study and because all provinces of Flanders returned questionnaires, we consider these results to be representative of all Flemish Catholic hospitals. Response rate from nursing homes was lower (62%). Although this relatively low response rate was satisfactory, it nonetheless prompted us to consider possible non-response bias, which might distort the results obtained from the nursing homes. Nursing homes that were familiar with the problems surrounding euthanasia were perhaps more inclined to take part in our study. Second, the relatively small sample of nursing homes that had ethics policies (30%) requires that we consider these results cautiously.

Comparison of our results with those from other studies is limited, because few studies on ethical policies on euthanasia have been undertaken. Nationwide research surveys on the prevalence, content, development, and communication of ethics policies on euthanasia have thus far been carried out only in The Netherlands [6]. Guarded comparisons can be made between our findings and those from the Dutch study [6], because both studies used similar designs and comparable questionnaires. However, differences in time, culture, healthcare organization, as well as ethical and legal aspects of euthanasia, should all be taken into account when interpreting the differences between and similarities of the Belgian and Dutch data.

Our study revealed a high to moderate prevalence of written ethics policies on euthanasia in Catholic hospitals

and nursing homes in Belgium (Flanders). The lower prevalence of ethics policies in nursing homes may indicate that general directors of nursing homes feel there is less need for such a policy at this type of institution. This is in accordance with the fact that euthanasia occurs less frequently in Belgian nursing homes than in hospitals. Between October 2002 and December 2003, 54% of the registered cases of euthanasia in Belgium were performed in hospitals, whereas only 5% were performed in nursing homes [24]. However, at the time of our survey, half of the nursing homes without an ethics policy reported that they were either developing a policy or were planning to develop one in the future. This indicates that nursing homes are interested in developing ethics policies on euthanasia.

Our study indicates that legislation, centrally developed ethics guidelines, and the experienced need for guidelines in clinical practice, greatly influence healthcare institutions to develop ethics policies. The end-of-life decisions caregivers make are not purely '*clinical*' but are also '*ethical*.' Indeed, decisions that impact human dignity and the meaningfulness and quality of life transcend the clinical discourse, and require instead ethical reasoning. Furthermore, relevant clinical practice and associated ethical decision-making processes will also be strongly influenced by the '*legal*' context of euthanasia in a particular country. Implementing the ethics policy in clinical practice reflects, in a way, the effort to integrate the purely legal assessment of a euthanasia request into a broader ethical framework that explicitly addresses death with dignity. This sort of understanding – i.e., the decision-making process in which the three different perspectives (clinical, ethical, judicial) are not considered separately but are considered as a unit – light help avert the rigid bureaucratic approach typical of such decision-making processes. The integration of these three perspectives might empower caregivers to be 'skilled companions' of patients requesting euthanasia; a companion who willingly views the patient as a real person and who searches together with the patient for the most dignified answer to the patient's request [25].

Besides the triangular forces – ethical, clinical, judicial – cited above as being involved in the development of euthanasia policies, we would add a fourth vector-religion. After the approval of the euthanasia law, Catholic healthcare institutions were challenged to find an answer how their Catholic identity (Christian anthropology) could be respected within the pluralist Belgian society wherein euthanasia was legally regulated. In fact, they had to find a publicly understandable and ethically well-founded answer to the question of how caregivers should best deal with euthanasia requests in Catholic healthcare institutions. A specific motivation to develop ethics policies was to limit the application of the euthanasia act as much as possible. In fact, by considering euthanasia only in cases of competent terminally ill patients and by applying the palliative filter procedure, euthanasia in Catholic healthcare institutions is now reduced to the so called 'states of necessity', where eventually euthanasia may be the lesser of two evils [14].

In Catholic hospitals and nursing homes, the board of directors and the daily managerial staff were involved in the development and approval of ethics policies. Haverkate et al. reported that 86% of Dutch physicians agreed that healthcare institutions should formulate ethics policies on euthanasia [26]. This observation may reflect the increasing awareness of the specific role and responsibility of the management in this matter. Our study indicates that the daily managerial staff and the board of directors were especially responsible for the final approval and confirmation of ethics policies. Also, the high prevalence of ethics policies in hospitals, together with their high response rate to our survey, might indicate that hospital management is aware of the importance of ethics policies and of their role in developing and approving these policies.

Also notable was the significant involvement of caregivers (members of ethics committees and palliative support teams) in the development and approval of ethics policies, especially in hospitals. In Belgium, ethics committees are primarily comprised of institutional caregivers [27]. The participation of caregivers in developing ethics policies on euthanasia is essential to bridge the gap between clinical practice and ethical and legal perspectives on the care of patients requesting euthanasia.

Despite these insights, further research is needed on the degree to which implementing ethics policies contributes to the care of patients requesting euthanasia. Indeed, to effectively implement ethics policies in healthcare institutions, more insight is needed into the professionals' awareness of the existence and content of ethics policies, their attitudes towards ethics policies, and their satisfaction with these policies [26].

According to our survey, communication of euthanasia ethics policies to institutional caregivers was moderate to good. Physicians and nurses especially were best informed about ethics policies, while other institutional caregivers were less informed. With respect to the growing multidisciplinary culture in healthcare institutions, it would be very important for all caregivers to be involved in and informed about ethics policies in order to ensure that they uniformly agree about how to deal with euthanasia requests.

With respect to communicating the policies to patients or residents and their relatives, we found important differences between hospitals and nursing homes. Nursing homes put forth great efforts to inform residents and their relatives about their ethics policies, while this appears to be at a threshold point in hospitals. One may question whether this finding is related to the particular kind of communication culture hospitals have towards patients and their relatives. One possible reason nursing homes have a more open communication policy than do hospitals is that the residents of nursing homes have much longer stays than do patients of hospitals. In Flemish Catholic hospitals, the lack of communication of ethics policies on euthanasia to patients

and their relatives is consistent with data from Dutch hospitals [6]. A more open communication policy towards residents and relatives, however, is clearly evident in Flemish nursing homes compared to Dutch nursing homes [6].

Our findings that hospitals do not inform patients and relatives about hospital ethics policies on euthanasia raise questions, especially when we consider the findings of a recent study revealing that poor communication exists between physicians and their patients and their patients' relatives when dealing with various medical, end-of-life decisions [1]. The incommunicative environment surrounding end-of-life care prompted Caritas Flanders and the Dutch State Commission on Euthanasia to make a plea in favor of developing clear institutional ethics policies on euthanasia with the explicit aim of communicating these policies to caregivers, patients/residents, and the relatives of patients/residents [8,10]. The Belgian National Council of Physicians also underscored the importance of timely, good, and clear communication between caregivers and terminally ill patients, stating that such communication should pave the way for patients, encouraging them to consult their physicians, other caregivers, and relatives about issues dealing with the manner, time, and place of their death [21]. However, the impact of this communication on a better end-of-life care for patients remains speculative. In this respect, Haverkate and van der Wal stress that specific attention should be paid to the way in which, and the moment at which patients are informed [9]. For example, if a patient receives an information leaflet on the euthanasia policy, without any further explanation, this can evoke fear or incomprehension. Therefore, further explorative research is needed to evaluate the opinions, wishes and experiences of patients with regard to the content of ethics policies and the way in which patients are informed about policies.

5.2. Conclusion

The high prevalence of ethics policies on euthanasia in Catholic healthcare institutions partly represents a response to the experienced need in clinical practice for support on medical, end-of-life decisions. The significant involvement of both clinicians and healthcare administrators in the development and approval of the ethics policies, together with a fairly good interchange of the policy among institutional caregivers, reflects significant willingness and commitment of institutions to address this need. However, maintaining quality care for patients requesting euthanasia requires more than the development of ethics policies on euthanasia and adequate communication of these policies. To what extent ethics policies contribute to a real support for physicians and nurses how to handle euthanasia requests is an interesting track for new research. Also the impact of communication about ethics policies on euthanasia to patients to support a better end of life care needs further exploration.

5.3. Practice implications

The study shows that legislation and centrally developed ethics guidelines might greatly influence healthcare institutions to develop ethics policies on euthanasia. Because of the important involvement of both caregivers and the management in the development and approval of the ethics policies on euthanasia, one can assume that these ethics policies are the outcome of a process of communication and deliberation between different partners within the institution about euthanasia. This cooperation might be fruitful to contribute to provide a support for caregivers in daily end-of-life practice.

All authors confirm all institution identifiers have been removed or disguised so the institutions described are not identifiable and cannot be identified through the details of the story.

References

[1] van der Heide A, Deliens L, Faisst K, Nilstun T, Norup M, Paci E, van der Wal G, van der Mass PJ. EURELD consortium. End-of-life decision-making in six European countries: descriptive study. Lancet 2003;362:345–50.
[2] Kuhse H, Singer P, Baume P, Clark M, Rickard M. End-of-life decisions in Australian medical practice. Med J Aust 1997;166: 191–6.
[3] Deliens L, Mortier F, Bilsen J, Cosyns M, Vander Stichele R, Vanoverloop J, Ingels K. End-of-life decisions in medical practice in Flanders, Belgium: a nationwide survey. Lancet 2000;356:1806–11.
[4] van der Maas PJ, van der Wal G, Haverkate I, de Graaff CL, Kester JG, Onwuteaka-Philipsen BD, van der Heide A, Bosma JM, Willems DL. Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in The Netherlands, 1990–1995. N Engl J Med 1996;335:1699–705.
[5] Magnusson RS. Euthanasia: above ground, below ground. J Med Ethics 2004;30:441–6.
[6] Haverkate I, van der Wal G. Policies on medical decisions concerning the end of life in Dutch health care institutions. J Am Med Assoc 1996;275:435–9.
[7] De Beer T, Gastmans C, Dierckx de Casterlé B. Involvement of nurses in euthanasia: a review of the literature. J Med Ethics 2004;30:494–8.
[8] Gastmans C. Caring for a dignified end of life in a Christian healthcare institution: the view of Caritas Catholica Vlaanderen. In: Schotsmans P, Meulenbergs T, editors. Euthanasia and palliative care in the low countries. Leuven: Peeters; 2005. p. 205–26.
[9] Haverkate I. Policies and guidelines on medical decisions concerning the end of life in Dutch health care. Thesis. Amsterdam: Thela; 1999.
[10] Dutch State Commission on Euthanasia. Rapport van de Staatscommissie Euthanasie. Deel 1. Advies [Report of the State Commission on Euthanasia. Part 1. Advice], 's Gravenhage: Staatsuitgeverij; 1985.
[11] Belgian Ministry of Justice. Wet betreffende de euthanasie [The Belgian Euthanasia Act]. Belgian Law Gazette of June 22, 2002. Available at: http://www.ejustice.just.fgov.be, accessed May 25, 2005.
[12] Broekaert B, Janssens R. Palliative care and euthanasia: Belgian and Dutch perspectives. In: Schotsmans P, Meulenbergs T, editors. Euthanasia and palliative care in the low countries. Leuven: Peeters; 2005. p. 35–70.
[13] Gastmans C, Van Neste F, Schotsmans P. Facing requests for euthanasia: a clinical practice guideline. J Med Ethics 2004;30:212–7.
[14] Gastmans C, Lemiengre J, van der Wal G, Schotsmans P, Dierckx de Casterlé B. Prevalence and content of written ethics policies on

euthanasia in Catholic healthcare institutions in Belgium (Flanders). Health Policy, in press.
[15] Zimbelman J. A blessing in disguise? Empowering Catholic healthcare institutions in the current healthcare environment. Christ Bioeth 2000;6:281–94.
[16] Engelhardt HT. The dechristianization of Christian healthcare institutions, or, how the pursuit of social justice and excellence can obscure the pursuit of holiness. Christ Bioeth 2001;7:151–61.
[17] Congregation for the doctrine of the faith, declaration on euthanasia. Origins 1980;10:154–7.
[18] National Advisory Committee on Bioethics. Advies nr. 1 betreffende de wenselijkheid van een wettelijke regeling van euthanasia [Advice nr. 1 concerning the desirability of a legal regulation on euthanasia]. Bioethica Belgica 1998;2–6.
[19] National Advisory Committee on Bioethics. Advies nr 9 betreffende het levensbeëindigend handelen bij wilsonbekwamen [Advice nr. 9 concerning life terminating acting in incompetent terminally ill patients]. Bioethica Belgica 1999;2–19.
[20] Nys H. A Comparative analysis of the law regarding euthanasia in Belgium and the Netherlands. Ethical Perspect 2002;9:73–85.
[21] National Council of Physicians. Advies betreffende palliatieve zorg, euthanasie en andere medische beslissingen omtrent het levenseinde [Advice concerning palliative care, euthanasia and other medical end-of-life decisions]. Tijdschr Nat Raad Orde Geneesheren 2003; 11:5–9.
[22] Dutch Law Gazette. Toetsing van levensbeëindiging op verzoek en hulp bij zelfdoding [Evaluation of ending life on request and assisted suicide]. Wet in Nederlands Staatsblad nr 194 [Law in Dutch Law Gazette nr 194]; 2001.
[23] Polit DF, Beck CT. Nursing research: principles and methods, 7th ed., Philadelphia, PA: Lippincott Williams and Wilkins; 2004. p. 366–7.
[24] Federal Control and Evaluation Committee on Euthanasia. Eerste verslag van de Wetgevende Kamers, September 22, 2002–December 31, 2003 [First report of the Constitutive Chamber, December 22, 2002–December 31, 2003], Brussels; 2004.
[25] Titchen A., Professional craft knowledge in patient-centered nursing and the facilitation of its development. Doctoral Dissertation. UK: University of Oxford; 2000.
[26] Haverkate I, van der Wal G, van der Maas PJ, Onwuteaka-Philipsen BD, Kostense PJ. Guidelines on euthanasia and pain alleviation: compliance and opinions of physicians. Health Policy 1998;44:45–55.
[27] Nys H. Ethics committees in Belgium. Eur J Health Law 1995;2: 175–6.